Washington State Department of Health

GUIDELINES FOR TESTING AND REPORTING DRUG EXPOSED NEWBORNS IN WASHINGTON STATE

EXECUTIVE SUMMARY

The purpose of this document is to provide guidance to health care providers and affiliated professionals about maternal drug screening and laboratory testing and reporting of drug-exposed newborns delivered in Washington State. This document was written in response to an increasing number of requests from hospital staff and attorneys seeking information on this complex topic. This work is a collaborative effort between the Washington State Department of Health (DOH) and the Department of Social and Health Services (DSHS).

One impetus for this effort to promote consistent practice among health care providers is a recent change in federal law. In 2003, Congress enacted the Keeping Children and Family Safe Act which requires each state, as a condition of receiving federal funds under the Child Abuse Prevention and Treatment Act, to develop policies and procedures "to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure." This includes a requirement that health care providers involved in the delivery or care of such infants notify Child Protective Services (CPS) of the occurrence of such condition in infants. This differs from the existing legal duty to report suspected child abuse or neglect in that the federal law specifies that such reports of prenatal substance exposure shall not be construed to be child abuse or neglect and shall not require prosecution of the mother.

DOH and DSHS cannot provide legal counsel on this topic, but the following key points are included in this guidelines document:

- Each hospital with perinatal/neonatal services should work with hospital risk management, nursing services, social service, medical staff, and local DSHS Children's Services to develop a defined policy for identifying intrapartum women and newborns for substance use/abuse. The hospital policy should be written in collaboration with local/regional CPS guidelines and include consent and reporting issues.
- Newborn testing should be performed only with evidence of newborn and/or maternal risk indicators.
- Newborn drug testing is done for the purpose of determining appropriate medical treatment.
- No uniform policy or state law exists regarding consent for newborn drug testing.
- Hospitals are encouraged to report all positive toxicology screens (mother or infant) to CPS. Reporting of this information, in and of itself, is not an allegation of abuse or neglect. The healthcare team acts as advocate for mother and newborn.
- Health care providers remain mandated reporters of child abuse and neglect under state law and are required to notify CPS when there is reasonable cause to believe a child has been abused or neglected. The presence of other risk factors or information combined with a positive toxicology screen may require that a report of child abuse or neglect be made to CPS in any given case.
- All women should be informed about planned medical testing, the nature and purpose of the test, and how results will guide management, including possible benefits and/or consequences of the test. Drug testing is based on specific criteria and medical indicators, not open-ended criteria such as "clinical suspicion" that invite discriminatory testing.

- If the woman refuses testing, maternal testing should not be performed. However, testing of the newborn may still occur if medically necessary or if newborn and/or maternal risk indicators are present. DOH strongly recommends that each institution develop, in collaboration with its attorneys, justification and process for newborn testing. The justification and process for newborn testing will be specific to the written policy of each institution.
- If there exists reasonable cause to believe leaving a newborn in the custody of the child's parent or parents would place the child in danger of imminent harm, a hospital may choose to place an administrative hold on the newborn and notify CPS per RCW.26.44.056. DOH recommends that each institution develop in collaboration with its attorneys the justification and process for placing administrative hold on a newborn. CPS may obtain custody of the newborn by court order or a law enforcement transfer of protective custody and may then give permission to test the newborn in order to safeguard the newborn's health.

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Washington State Department of Health

GUIDELINES FOR TESTING AND REPORTING DRUG EXPOSED NEWBORNS IN WASHINGTON STATE

Introduction

The purpose of this document is to provide consistent guidance to health care professionals and hospitals related to maternal screening* and testing** and reporting drug-exposed newborns born in Washington State hospitals.

This document is a collaborative effort between the Department of Health (DOH) and Department of Social and Health Services (DSHS), two separate agencies. The Washington State Department of Health is responsible for preserving public health, monitoring health care costs, maintaining minimal standards for quality health care delivery, and planning activities related to the health of Washington citizens. The Department of Social and Health Service is the state umbrella social service agency. Its mission is to improve the quality of life for individuals and families in need by helping people achieve safe and self-sufficient, healthy and secure lives.

Indicators for Testing

Maternal drug testing is based on specific criteria and medical indicators, not open-ended criteria such as "clinical suspicion" that invite discriminatory testing. Evidence-based risk indicators should also be used as a guide for performing drug toxicologies on newborns. Due to the limited time window for detection of drugs, difficulties in collecting specimens, as well as costs incurred for testing, all newborns with evidence of newborn risk indicators (Table 1) and/or maternal risk indicators (Table 2) should be tested for drug exposure, unless a different medical cause is identified. Laboratory testing of newborns should be done for the purpose of determining appropriate medical treatment. It is unnecessary to test a newborn whose mother has a positive drug toxicology; her newborn is presumed to be drug exposed.

Hospital Policy

Each hospital should work with risk management attorneys, nursing, social service, and medical staff to develop a defined policy for identifying intrapartum women and newborns for substance use/abuse. This policy should address specific evidence-based criteria for testing the woman and her newborn, timing of tests, test types, and consent issues. The justification and process for newborn testing will be specific to the written policy of each institution. All healthcare providers should be informed of the policy and educated in its use. Health care professionals may need additional education regarding how to approach and motivate women to make an informed choice regarding testing.

For in-depth guidance for screening, identifying and referring women for treatment please refer to the *Substance Abuse During Pregnancy: Guidelines for Screening* best practice booklet located online at: http://www.doh.wa.gov/cfh/mch/documents/screening_guidelines.pdf
Another referral resource is the *Pregnant Women Chemical Dependency/Abuse Resource Guide/Matrix*. http://www.doh.wa.gov/cfh/mch/documents/dasa_resource_guide_1_02.doc

*Screening: methods used to identify risk of substance abuse during pregnancy and postpartum, including self-report, interview and observation.
**Testing: process of laboratory testing to determine the presence of a substance in a specimen.

Table 1
Newborn Risk Indicators
It is not necessary to test a newborn with signs of drug withdrawal whose mother has a positive drug test. This newborn may be presumed drug-exposed. This does not preclude doing a separate test of the child if medically indicated.

Newborn characteristics that may be associated with maternal drug use include: (ACOG, 2004)

- Positive maternal toxicology screen
- Jittery with normal glucose level
- Marked irritability
- Preterm birth
- Unexplained seizures or apneic spells
- Unexplained intrauterine growth restriction
- Neurobehavioral abnormalities
- Congenital abnormalities
- Atypical vascular incidents
- Myocardial infarction
- Necrotizing enterocolitis in otherwise healthy term infants
- Signs of neonatal abstinence syndrome: marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis (Finnegan, 1986; see Appendix): *Note: Neonatal signs of fetal dependence may be delayed as long as 10-14 days, depending upon the half-life of the substance in question.*

Preterm infants are less likely to overtly exhibit at-risk behaviors in spite of substance exposure. Immature organ systems may modify test results.

Table 2
Maternal Risk Indicators
Maternal characteristics that suggest a need for biochemical testing of the newborn include: (ACOG, 2004)

- No prenatal care
- Previous unexplained fetal demise
- Precipitous labor
- Abruptio placentae
- Hypertensive episodes
- Severe mood swings
- Cerebrovascular accidents
- Myocardial infarction
- Repeated spontaneous abortions

Consent Issues for Testing
Controversies still exist regarding the extent to which maternal consent is required prior to toxicology testing of either the mother or the newborn. No uniform policy or state law exists regarding consent for newborn drug testing. This is a complex issue and hospitals, with advice from their risk management staff and legal counsel, should determine when it is necessary to obtain specific consent to test newborns and their mothers. A positive drug test is not in itself a diagnosis, nor does substance abuse by itself prove child neglect or inadequate parenting capacity (ACOG, 2005).

Refer to *Substance Abuse During Pregnancy: Guidelines for Screening,* for a more detailed discussion of consent issues: http://www.doh.wa.gov/cfh/mch/documents/screening_guidelines.pdf

The importance of clear and honest communication with the woman regarding drug testing cannot be overstated. The health care team should act as advocate for mother and newborn. This relationship is more difficult to establish if a woman is notified of testing after the fact. Therefore, all women should be informed about planned medical testing. Explain and document the nature and purpose of the test and how results will guide management, including possible benefits and/or consequences of the test.

The rationale for testing and the parental discussion should be documented in the medical record. If the woman refuses testing, this should be documented and maternal testing should not be performed. **In Ferguson v Charleston, SC, 532 US 67 (2001) the Supreme Court ruled that testing without maternal consent for the purposes of criminal investigation violated the mother's Fourth Amendment rights. (Lester, 2004)**

However, testing of the newborn may still occur if newborn and/or maternal risk indicators are present. DOH strongly recommends that each institution develop, in collaboration with its attorneys, justification and process for newborn testing. If there exists reasonable cause to believe leaving a newborn in the custody of the child's parent or parents would place the child in danger of imminent harm, a hospital may choose to place an administrative hold on the newborn and notify CPS per RCW.26.44.056. DOH recommends that each institution develop in collaboration with its attorneys the justification and process for placing administrative hold on a newborn. CPS may obtain custody of the newborn by court order or a law enforcement transfer of protective custody and may then give permission to test the newborn in order to safeguard the newborn's health.

See Table 3 for information about newborn drug testing. The procedure for obtaining samples for testing is institution-specific. See attached policy samples for guidance.

Comprehensive guidelines for hospital care of the drug-exposed newborn are beyond the scope of this document. See Table 4 for basic information about newborn management.

Table 3
Newborn Drug Testing

About Newborn Urine Toxicologies:

- Correlation between maternal and newborn test results is poor, depending upon the time interval between maternal use and birth, properties of placental transfer, and time elapsed between birth and neonatal urine collection.
- The earliest urine of the newborn will contain the highest concentration of substances.
- Failure to catch the first urine decreases the likelihood of a positive test.
- Threshold values (the point at which a drug is reported to be present) have not been established for the newborn.
- Fetal effects cannot be prevented by newborn testing.
- Newborn urine reflects exposure during the preceding one to three days.
- Cocaine metabolites may be present for four to five days.
- Marijuana may be detected in newborn urine for weeks, depending on maternal usage.
- Alcohol is nearly impossible to detect in newborn urine.

Other Methods of Newborn Drug Testing**:**

- **Meconium:** Meconium in term infants reflects substance exposure during the second half of gestation; preterm infants may not be good candidates for meconium testing. The high sensitivity of meconium analysis for opiate and cocaine and the ease of collection make this test ideal for perinatal drug testing. Meconium analysis is available for mass screening with an enzyme

immunoassay kit or by radioimmunoassay. Cost of analysis per specimen approximates the cost of urine toxicology. (J Pediatrics 2001; 138:344-8)

- **Breast milk:** Breast milk is not a viable alternative for drug testing.
- **Hair:** Hair testing has high sensitivity for detecting perinatal use of cocaine and opiate but not for marijuana. Hair testing is restricted to a few commercial laboratories and the cost of testing is higher than for meconium. (J Pediatrics 2001; 138:344-8)
- **Umbilical cord segments** may be a viable testing medium in the future, but is evolving technology at present. More information is available at www.usdtl.com

Table 4
Management of a Newborn with a Positive Drug Toxicology

- Confirm any positive test with gas chromatography/mass spectroscopy (GC/MS) particularly if opiates are found.
- Consider the fact that intrapartum drugs prescribed to control labor pain can be detected in meconium.
- Notify newborn's provider for diagnostic work-up.
- Use the Neonatal Abstinence Scoring tool to document symptoms of narcotic withdrawal. See Appendix D for sample.
- Newborn assessment should include newborn health status, maternal drug use history and current family situation. Document assessment of family interaction (or lack of interaction). Include positive observations as well as areas of concern.
- Notify social worker or other designated staff member to coordinate comprehensive drug/alcohol assessment and outside referrals, including CPS. If designated staff member is not available, reporting to CPS is the responsibility of all health care providers. CPS after hours, weekends and holidays intake telephone number is: 1-800-562-5624.
  Note: CPS may use a patient's chart as documentation in court. A release of information is not required.

Reporting to Children's Administration (CPS)

Hospitals should contact their local DSHS Children's Services office and request an in-service on mandatory reporting and other Children's Protective Services (CPS) processes. The hospital's risk management staff should attend the in-service. After the in-service, parties may have a better idea of points needing clarification. Historically, local CPS offices have varied in how they handle prenatal drug use and positive drug screens due to the individual risk and protective factors within each family. Starting at the local level is important for developing key relationships and ensuring smooth and consistent procedures. Hospitals are encouraged to report all positive toxicology screens (maternal and newborn) to CPS and are required to report infants born as drug affected by illegal substance abuse or experiencing withdrawal symptoms resulting from prenatal exposure pursuant to the Keeping Children and Families Safe Act of 2003. Health care providers are mandated to report child abuse or neglect to CPS. Resources about reporting are available at the Washington DSHS Children's Administration website: http://www1.dshs.wa.gov/ca/general/index.asp

Hospital policy should indicate under what circumstances positive drug toxicology testing will be reported to CPS. The current Washington State legal mandate to report newborns exposed to drugs is subject to interpretation. The mandate reporting statute, RCW 26.44.030(1)(a), provides that mandated reporters must report when they have "reasonable cause to believe that a child has suffered abuse or neglect." It is not the mandated reporter's responsibility to prove drug use, child abuse or neglect, but rather to report suspected drug users with or without positive drug testing in order to enable CPS to investigate further, if necessary. The hospital policy should be written in collaboration with local/regional CPS guidance and include reporting criteria.

Appendix A
References and Resources:

American Academy of Pediatrics Committee on Drugs. 1998. Neonatal Drug Withdrawal. *Pediatrics*; 101:1079-1088.

American Academy of Pediatrics Committee on Substance Abuse. 1998. Tobacco, Alcohol and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse. *Pediatrics*; 101:125-128.

American Academy of Pediatrics Committee on Substance Abuse. 2001. Alcohol Use and Abuse: A Pediatric Concern. *Pediatrics*; 108: 185-189.

American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2002. *Guidelines for Perinatal Care, Fifth Edition*. Elk Grove Village IL.

American College of Obstetricians and Gynecologists. 2004. *At-Risk Drinking and Illicit Drug Use: Ethical Issues in Obstetric and Gynecologic Practice*, ACOG Committee Opinion, Number 294.

American College of Obstetricians and Gynecologists. 2005. Substance Use: Obstetric and Gynecologic Implications. In *Special Issues in Women's Health*. ACOG Committee on Health Care for Underserved Women.

Weiners and Finnegan LP (2002). Drug Withdrawal in the Neonate in Handbook of Neonatal Intensive Care, 5th Edition. Merenstein and Gardner, eds. CV Mosby: 163-178.

Finnegan LP. 1986. Neonatal abstinence syndrome: assessment and pharmacotherapy. In: Rubaltelli FF, Granati B, eds. *Neonatal therapy: an update*. New York: Excerpta Medica:122-46.

Lester BM, et al. 2004. Substance use during pregnancy: time for policy to catch up with research. *Harm Reduction Journal*; http://www.harmreductionjournal.com/content/1/1/5

Ostrea EM, et al. 2001. Estimates of illicit drug use during pregnancy by maternal interview, hair analysis, and meconium analysis. *Journal of Pediatrics*;138:344-8.

Washington State Department of Health. 2002. *Substance Abuse During Pregnancy: Guidelines for Screening.* http://www.doh.wa.gov/cfh/mch/documents/screening_guidelines.pdf

Additional Resources

To order or download "The Parent's Guide to CPS" (mentioned in letter on Page 11):
http://www/dshs.wa.gov/ca/pubs/pubcats.asp?cat=Child_Abuse_and_Neglect

Swedish Medical Center, Seattle: Center for Perinatal and Pediatric Excellence (telephone: 206-215-2073)

Washington State Department of Health, Maternal and Infant Health Program (telephone: 360-236-3563)

Washington DSHS Children's Administration website – video and materials for mandatory reporters:
http://www1.dshs.wa.gov/ca/general/index.asp

CPS after hours, weekends and holidays intake telephone number: 1-800-562-5624.

Washington State Hospital Association (telephone: 206-216-2531)

Appendix B

Guidelines for Obtaining Consent from Parents for Infant Drug Testing

Set the Scene

The healthcare provider's attitudes and feelings about maternal substance use, as well as the environment in which this discussion takes place, often influences the success or failure of obtaining parental consent for infant drug testing. Often the way the subject is approached will be the major determinant in obtaining consent.

- Be aware of your own beliefs and values that may interfere with your ability to remain neutral and non-judgmental.
- Assess the environment for privacy and when possible, discuss the issue in a non-emergent setting.
- Attend to your non-verbal behavior including body stance, facial expression, eye contact, muscle tension, and arm and hand positioning.

Introduce the Topic

- Begin with open ended questions. Ask the mother how she is doing and what she needs.
- Reflect back to the mother what she has just stated and respond to any questions.
- Inform the mother that there is another topic you need to discuss.
- Give reasons /describe in a non-judgmental manner why you want to test her infant for evidence of maternal drug use during pregnancy (see script below).
- If the testing is requested by Child Protective Services, inform the mother of this and bring the focus back to the health of the mother and infant.
- Ask if she has any questions; if yes, answer them to the best of your ability.
- Ask permission for consent: "Do we have your permission to test the baby?" If yes, thank the mother for her cooperation and reinforce that she is working in the best interest of her child.
- Review what the testing process involves for the baby.

If the Parent is Angry, Resistant, Agitated and/or Defensive:

- Determine if the parent is intoxicated or has mental health issues that will interfere with her ability to comprehend.
- Stay calm.
- Do all of the steps described above: bring the focus back to the health of the infant, re-explain that her cooperation with this step shows that she is interested in the health of her baby.
- Allow more time for the parent to talk about what is happening and her concerns. Reassure as appropriate.
- Be matter of fact about the issue while remaining supportive and non-judgmental.
- Refer to your agency's policies regarding drug testing and Child Protective Services protocols.

Sample Scenario:

Hello Mary, how are you doing today? Do you have any questions or concerns you'd like to talk about?

(*Patient responds and her questions concerns are addressed).*

Those are good questions, Mary. Now I have something else to discuss with you that will help us provide the best care for your baby. This may be uncomfortable to discuss but it is very important.

(*Give patient time to respond*).

There is some concern about your drug use during this pregnancy and the impact it has had or may have on your baby. I know you want the best for your baby and wouldn't purposefully do anything to hurt her. When a woman uses drugs when she is pregnant or breastfeeding, there is a risk to the baby's health. We would like to get your permission to test your baby for drugs so we can give her the best medical care. Will you sign a consent form to test your baby?

If parent responds "Yes": I know this is scary but it's the best decision for your baby. Here is the consent form. Is there anything you'd like me to know or do you have any questions?

(*Patient Response*)

Okay, do you want to hear how this done and what you may be asked to do?

If parent responds "No": (*Use the same steps as above until the patient refuses*.)
I can't imagine how scary this sounds to you and I hope we can come to an agreement about you consenting but if we can't I am still required to do what I think is needed to make sure your baby is given appropriate medical care. Can we talk about this more?

(*Client nonresponsive or says "No"*)

This facility and I are required to notify CPS when there is concern about the effect a parent's drug use has on the health of an infant. What happens now is staff here will contact CPS to let them know the situation. Your baby may then be placed on an administrative hold. When CPS gains custody, CPS can then give permission to test the baby. It would be great if we get consent and test now and begin any treatment your baby may need. What do you think?

(*If the patient still refuses, follow the agency protocols and do what is necessary to keep the baby in the hospital and complete the testing after CPS has approved).*

"OK, I hear you saying no to drug testing for your baby. I'll let the staff here know of that decision and we'll take it from here. It's important for you to know that your baby may still get tested for drugs. We would do that to protect your baby's health. We'll keep you informed about what will happen next."

Appendix C

Sample Parent Letter:
Information for parents whose newborn has been placed on administrative hold

Hospital Letterhead

Dear Parent:

This letter tells about what is happening to you and your newborn. People who care for you and your baby have concerns about your drug and/or alcohol use and the impact it has on your baby. For this reason, your newborn has been placed on an administrative hold at the hospital. This means that you may not leave the hospital with your baby at this time.

The enclosed purple booklet "Parent's Guide to Child Protective Services (CPS)" provides some important information that will help you through this time. Please take a few minutes to read it. You may ask your questions to the person from CPS who will come and speak with you at the hospital, or at your house if you have already left the hospital.

Each person's situation is different, and the social worker from CPS will explain what will happen next. This social worker will talk with you and develop a plan for keeping your newborn safe. This person will give you information about services for you and your new baby. This may include dates and times of appointments or meetings that you need to attend.

We know this is a difficult time. Your nurses and hospital social worker want to help you in your efforts to ensure the health and safety of your baby. Please ask questions and let your nurses and social worker know your thoughts and feelings.

We believe the best place for a new baby is with the family. We hope you will work with CPS to make a safe and healthy home for your new baby.

Sincerely,

XXXXXX
Enclosure

Appendix D

Neonatal Abstinence Scoring System

Morphine Sulfate		Dose										
System Date/Time	Signs and Symptoms	Score										
Central Nervous System Disturbance	Crying: Excessive high pitched Crying: continuous high pitched	2 3										
	Sleeps < 1 hour Sleeps < 2 hours after feeding Sleeps < 3 hours after feeding	3 2 1										
	Hyperactive Moro reflex Markedly hyperactive Moro reflex	2 3										
	Mild tremors: Undisturbed Moderate-severe tremors: Undisturbed	3 4										
	Mild tremors: Disturbed Moderate-severe tremors: Disturbed	1 2										
	Increased muscle tone	2										
	Excoriation (specify area)	1										
	Myoclonic Jerks	3										
	Generalized convulsions	5										
Metabolic, Vasomotor, and Respiratory Disturbances	Sweating	1										
	Fever 37.2-38.3^{O}C Fever > 101 (>38.4^{O}C)	1 2										
	Frequent yawning (>3)	1										
	Mottling	1										
	Nasal Stuffiness	1										
	Sneezing (>3)	1										
	Nasal flaring	2										
	Respiratory rate (>60/min.) Respiratory rate (>60/min. with retractions)	1 2										
Gastro-Intestinal Disturbances	Excessive sucking	1										
	Poor feeding	2										
	Regurgitation Projectile vomiting	2 3										
	Loose stools Watery stools	2 3										
	Total Score											
	Initials of Scorer											

Adapted from Finnegan, L.P. 1986. Neonatal abstinence syndrome: assessment and pharmacotherapy. In F.F. Rubatelli and B. Granadi (ed.) Neonatal therapy: an update. Exerpta Medica, NY.

Addressograph

Appendix E: Sample policies and procedure #1 (must be modified for use by individual institutions. Please consult with Pediatric Pharmacologist for most current information)

SAMPLE PROTOCOL FOR NEONATES EXPOSED TO CONTROLLED SUBSTANCES IN UTERO

PURPOSE: To outline the nursing management of a neonate exposed to controlled substances, such as opiates, methadone, methamphetamines, benzodiazepines, cocaine, marijuana, hallucinogens.

LEVEL: Interdependent
*Requires MD order for dependent function

INDICATIONS FOR USE: Infants whose mothers use controlled substances during pregnancy are at risk for experiencing acute drug withdrawal symptoms. These symptoms can contribute to physiological deterioration in patient status. These patients must be scored every 2-4 hours using the Finnegan Neonatal Abstinence Score (NAS). If the average score is 8 for three consecutive scores or average of any two consecutive scores is 12 or higher, consider appropriate pharmacologic agents.

TIMING OF THE NEONATAL ABSTINENCE SCORE (NAS):

1. Place NAS score sheet and NAS definitions at patient bedside.
2. At two (2) hours after birth, use the NAS score sheet to assess the baby's behavior that occurred during the previous two (2) hours.
3. If the score is 7 or less, continue to assess and score the baby every four (4) hours, by adding the score of **each** symptom observed throughout the previous four (4) hours.
4. If any score is 8 or greater, assess and score the baby every two (2) hours.
5. If medication is required for withdrawal symptoms, continue to assess and score the baby every two (2) hours if the score is 8 or greater; score the baby every four (4) hours if the score is 7 or less.

What is the significance of the score?

SCORE:

0	Optimal behavior
1-7	Need conservative nursing measures to limit withdrawal symptoms
8	If there are three consecutive scores of 8 or that average 8, or two consecutive scores of 12 or more, then pharmacotherapy initiation is indicated. (If infant is in the Newborn Nursery, transfer to special care nursery for pharmacotherapy.)

ASSESSMENT:

6. Assess the patient for signs of withdrawal using the NAS form and the definitions for scorer.

REPORTABLE CONCERNS:

7. Report promptly to the newborn's medical care provider:
   - -Seizures
   - -Diarrhea (6 or more stools per day) or water ring
   - -Vomiting > 10% of intake
   - -Tachycardia (HR > 20 bpm over baseline, not related to hypovolemia)
   - -Systolic B/P > 90 mm Hg
   - -Continuous inconsolable crying despite nursing intervention
   - -Increased ventilator support

NURSING INTERVENTIONS:

1. Reduce environmental stimuli at patient's bedside:
   a. Avoid talking at bedside.
   b. Decrease environmental lighting.
   c. Attempt to place baby in a room with low activity/noise level.
   d. Present one stimulus at a time; i.e., voice, face, rocking.
   e. Move baby away from telephone, sink and high traffic areas.

2. Possible measures to console irritable infant:
   a. Nest with blanket rolls for containment and flexion
   b. Offer pacifier
   c. Try heart beat audiotapes
   d. Decrease stimulation at first signs of distress
   e. Try vertical rocking

PHARMACOLOGIC THERAPIES

1. **OPIATE WITHDRAWAL (METHADONE, HEROIN, HYDROCODON, MORPHINE, OXYCODONE, HYDROCODONE)**

Use of oral morphine is recommended when the Neonatal Abstinence Score (NAS) is 8 or higher for three consecutive scores, or when the average of any three consecutive scores is 8 or higher. Alternatively if the score is 12 or higher for two consecutive intervals, or the average of any two consecutive scores is 12 or higher, therapy should be initiated at the appropriate detoxicant dose before more than four (4) hours elapse.

An increase in oral morphine dose is recommended at anytime after the initiation of therapy when there have been three consecutive total scores of 8 or higher, or an average of any three consecutive total scores of 8 or higher (scores done at two (2) hour intervals).

Consult pediatric pharmacist for dosing regimen.
Cardiorespiratory monitoring is recommended during treatment.

Consider concomitant use of phenobarbital with oral morphine because some studies show it to be effective in facilitating more rapid withdrawal of oral morphine. Preliminary studies suggest that improved neuro behavioral organization may result in more rapid recovery from opiate withdrawal.

PHARMACOLOGIC THERAPIES (Cont.)

2.

NON-OPIATE WITHDRAWAL (COCAINE, METHAMPHETAMINE, ECSTASY, ETC.)

Use of phenobarbital is recommended when the total abstinence score is 8 or higher for three consecutive scores, or when the average of any three consecutive scores is 8 or higher. Alternatively, if the score is 12 or higher for two consecutive intervals, or the average of any two consecutive scores is 12 or higher, therapy should be initiated at the appropriate phenobarbital dose before more than 4 hours elapse.

An increase in phenobarbital dose is recommended at anytime after the initiation of therapy when there have been three consecutive total scores of 8 or higher, or an average of any three consecutive total scores of 8 or higher (scores done at two (2) hour intervals).

Consult pediatric pharmacist for dosing regimen.
Cardiorespiratory monitoring is recommended during treatment.

Reference:

1. Finnegan, L. Neonatal Abstinence, Current Therapy in Neonatal-Perinatal Medicine, 2nd Ed., Nelson, E., B. C. Decker, 1990, pp. 314-320.
2. D'Apolito, K. (1996). Symptoms of Withdrawal in Drug-exposed Infants, *Mother Baby Journal*, 1(2), 7-14.
3. Adapted from Oakland Children's Hospital, Department of Nursing Opiate Weaning Management Protocol.
4. D'Apolito, K. (1994). A Scoring System for Assessing Neonatal Abstinence Syndrome. Seattle: University of Washington.
5. Theis, J., Selby, P., Ikizler, Y., and Koren, G., (1997) Current Management of the Neonatal Abstinence Syndrome: A critical Analysis of the Evidence. Biology of the Neonate, F1, 345-356.
6. Rao, R., and Desai, N., (2002). Oxycotin and Neonatal Abstinence Syndrome, *J. Perinatology*, 22, 324-325.
7. Coyle, MG, Ferguson, A., Lagasse,L., Oh, W., Lester, B., (2002). Diluted tincture of opium (DTO) and phenobarbital versus DTO alone for neonatal opiate withdrawal in term infants. *The Journal of Pediatrics*, 140 (5), 561-4.

Orig:
REVIEWED: REVISED: APPROVED:

SAMPLE PROTOCOL FOR MANAGEMENT OF PERINATAL/NEONATAL CHEMICAL USE

PURPOSE: To outline nursing management responsibilities for all aspects of the admission assessment of a perinatal patient substance abuse.

LEVEL: Independent - RN
* Requires MD order

SUPPORTIVE DATA:

1. The nurse should strive to establish a positive, supportive environment in which to elicit information about possible chemical abuse during pregnancy.
2. The RN's role is primarily to assess and collect information (including results of drug screens) that can be useful to other members of the health care team; physicians, social workers, etc. in providing care to the affected patient.
3. An order for an administrative or medical hold on a baby in the hospital may only come from a physician, hospital administrator or court order.

MATERNAL INDICATIONS: Maternal indicators for newborn testing include:

1. No prenatal care
2. Previous unexplained fetal demise
3. Precipitous labor
4. Abruptio placentae
5. Hypertensive episodes
6. Severe mood swings
7. Cerebrovascular accidents
8. Myocardial infarction
9. Repeated spontaneous abortions

NEONATAL INDICATIONS: Neonatal indicators for testing include: (ACOG, 2004)

1. Positive maternal toxicology screen
2. Jittery with normal glucose level
3. Marked irritability
4. Preterm birth
5. Unexplained seizures or apneic spells
6. Unexplained intrauterine growth restriction
7. Neurobehavioral abnormalities
8. Congenital abnormalities
9. Atypical vascular incidents
10. Myocardial infarction
11. Necrotizing enterocolitis in otherwise healthy term infants
12. Signs of neonatal abstinence syndrome: marked irritability, high pitched cry, feeding disorders, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis (Finnegan, 1986; see Appendix):
13. Note: Neonatal signs of fetal dependence may be delayed as long as 10-14 days, depending upon the half-life of the substance in question.

ASSESSMENT: The nurse will assess for:

1. Documentation of chemical use/abuse during pregnancy on prenatal records from physician offices and/or Maternity Support Services and/or Social Services.
2. Type of drugs/alcohol, amount used, frequency, date last used.
3. Details of participation in/completion of a drug treatment program.
4. CPS or other agency involvement in relationship to drug usage.
5. Chemical use/abuse by other person/s in home. Nurse may request that social worker ask these detailed questions.
6. Document risk factor/signs and symptoms of mother or neonate.

SAMPLE PROTOCOL FOR PERINATAL DRUG TESTING

CONSENTS FOR TESTING:

Maternal:

1. Drug testing on pregnant or postpartum patients will be done only with the consent of the patient. Consent will be obtained prior to obtaining the drug test with exception for medical emergency concerns. Verbal patient consent is acceptable if it is documented on the patient's chart. Drug testing will be done in an emergency medical situation (i.e., emergency c/s for abruption), mother's consent is not necessary. If pregnant or postpartum patient refuses to give consent for testing, drug testing will not be done. Refusal of consent to screen will also be documented. The newborn's physician will be notified of refusal.

Infant:

2. A drug test on the newborn will be considered when the identified criteria are present. Parental awareness of planned testing is advisable.

Consent for Release of Information

3. When mother has a CPS alert, receiving services for Child Protection Services (CPS), obtain her consent for release of information for each agency.

MANAGEMENT:

The RN informs the attending/on call physician of the results of an assessment which indicates possible chemical use/abuse.

*1. The RN requests an order for a urine drug test to be done on the mother. If the physician declines to order a drug screen and substance use/abuse is suspected, document conversation with the physician and notify the infant's physician. If the infant's physician declines, notify medical director and house supervisor/social worker.
Inform patient of purpose of urine collection and document patient response in the medical record.

2. The nurse collects the specimen from the mother after order received.

3. The nurse completes referral to Social Services as soon as possible after admission. If Social Services is not available, call Child Protective Services.

4. Notify physician who will be caring for newborn (if different from admitting physician) of suspected or known chemical use/abuse and other pertinent details of mother's history.

*5. Request an order for a urine/meconium drug test on the newborn.

6. In the situation where CPS/Social Services is not available and where the following behavior is observed, notify the house supervisor and request an administrative hold. Document the observed behavior and intervention.
   a. Obvious rejection of baby
   b. Demonstrates abusive behavior/neglect towards baby
   c. Unable to care for self or baby

7. When toxicology test is positive, notify social worker who will contact outpatient behavioral health services for a chemical dependency consult. A chemical dependency professional (CDP) will contact mother for the consult/referral to the community.

DOCUMENTATION:

8. Patient Record

*Testing: Process of laboratory testing to determine the presence or absence of a substance in a specimen.

Original:
REVIEWED: REVISED: APPROVED:

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Appendix F
Sample policy and procedure for testing of newborns #2 (must be modified for use by individual institutions)

DRUG TESTING OF NEWBORN INFANTS

POLICY: Newborn drug (toxicology) testing will be undertaken only after careful assessment and documentation of medical and/or social indications.

Medical Indications:

When a newborn is exhibiting signs and symptoms consistent with drug toxicity or withdrawal, a drug test (of urine, blood, meconium, etc.) may be indicated for diagnosis or management. In such cases, the physician should clearly document in the patient's chart the medical indications for obtaining a drug test from the infant. Social Work staff should be consulted to evaluate the family. The physician will inform the family of the results of the test.

Social Indications:

When Social Work staff or CPS workers need to document drug use during pregnancy, they should contact the mother's health care provider and request a maternal drug toxicology test. When this is not possible, a newborn drug test (acknowledging its many limitations) may be submitted. The attending physician and social worker will jointly discuss with the patient's parents the reasons for the test and will request permission for testing.

If permission is granted, the physician will document in the chart the indications for the test. When the results are returned, the physician will inform the parents of the results. If permission is refused, the discussion and refusal should be documented in the chart. Consultation with the hospital attorney is indicated if the physicians or social worker believe that the test would be in the best interests of the child.

Submitted by:
Reviewed by:
Reviewed by
Revised by:

Approved by Medical Executive Committee:

APPROVED BY:

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ORIGINATED: _____
REVIEWED: _____
REVISED: _____